ATTACHMENT 1: PROGRAM COVER PAGE

PROGRAM INFORMATION

Contractor Name:	Department of Mental Retardation
Program Type:	Document ID #
Program Name:	UFR Program #:
Program Address:	MMARS Program Code:
City/State/Zip	Other Reference Information (Information Purposes Only):
Contact Person:	Contact Person:
Telephone:	Telephone:

RFR INFORMATION: Attached   RFR Reference #
                          legislative exemption   emergency   collective purchase   interim   amendment

SCOPE OF SERVICES: Bidders Response Attached   Description of Services Attached

TOTAL ANTICIPATED CONTRACT DURATION: to

INITIAL DURATION: to

OPTIONS TO RENEW: options to renew for   years each option

FISCAL TERMS

	FUNDING SUMMARY					
	Prior Years		Current Year		Future Years	
	FY	Amount	FY	Amount	FY	Amount
PRICE IS ESTABLISHED THROUGH: (CHECK 1,2, OR 3)						
OPTION 1: PRICE AGREEMENT (list price) $ rate regulation (if any)						
OPTION 2: SUMMARY BUDGET (✶ lines only) unit rate cost reimbursement other						
OPTION 3: COMPLETE BUDGET cost reimbursement						
unit rate	Tot:		Tot:		Total: $	
other	**Multi-Year Total:**					

CURRENT
MAX OBLIGATION:$ UNIT RATE:$ per   # BILLABLE UNITS:

ADDITIONAL PAYMENT OR PRICE SPECIFICATIONS:

PURCHASE OF SERVICE - ATTACHMENT 3: FISCAL YEAR PROGRAM BUDGET

Program Name:	Document ID#:	MMARS Code:	Program Type _____	UFR Prog. #

		Current		Amend. Change		New		COST REIMBURSEMENT ONLY		
		FTE	Amount	FTE	Amount	FTE	Amount	**Offset	Source	Reimbursable Cost
	Program Component									
UFR Title #	Direct Care/Program Support Staff/Overtime/ Shift Differential & Relief (Titles 101-141)									
	SUBTOTAL STAFF									
150	Payroll Taxes									
151	Fringe Benefits									
T	**Total Direct Care/Program Staff**									
Title	Occupancy									
301	Program Facilities									
*** 390	Fac. Oper/Main/Furn									
T	**Total Occupancy**									
UFR Title	Other Direct Care/Program Support									
201	Direct Care Consultant									
202	Temporary Help									
203	Clients/Caregivers. Reimb/Stipends									
206	Subcontract Dir.Care									
204	Staff Training									
205	Staff Mileage/Travel									
207	Meals									
208	Contracted Client Trans.									
*** 208	Vehicle Expenses									
*** 208	Vehicle Depreciation									
209	Incid. Health/Med Care									
211	Client Per. Allowances									
212	Prov. of Material Good									
214	Direct Client Wages									
214	Other Commercial Prod. & Svs.									
*** 215	Program Supplies/Mat									
T	**Total Other Direct Care/Program**									
Title	Direct Admin Expenses									
2160	Program Support									
*** 410 & 390	Other Direct Administrative Expenses									
T	**Total Direct Administrative Exp.**									
T	**SUBTOTAL PROGRAM COSTS**									
*** 410 T	**Agency Admin. Support Allocation**	$								
		$								
T	**PROGRAM TOTAL**									

** A. $ _____ **Subtotal of offsets which are for non-reimbursable costs.**

** Non-reimbursable costs must be shown in detail on Attachment 5 when the program is subject to the provisions of Federal OMB Circular A-122 and/or 808 CMR 1.00.

*** Contractor's Board approved capitalization level relative to any negotiated expense costs in lines 208, 215, 390 or 410 is $_____

11/17/03

FY   Contractor Name: Amend #, If Appl.:   If Federal Funds, CFDA #:
                                          (for internal DMR use) within FY amendment #: _____
ATTACHMENT 4: RATE CALCULATION/MAXIMUM OBLIGATION CALCULATION PAGE

Modified Attachment 4: to be used with all Dept. of Mental Retardation contracts

Program Name:	**Document ID#:**	**MMARS Code:**	**Program Type**	**UFR Prog. #**

AMENDMENT #, IF APPLICABLE:

UNIT RATE CALCULATION
1.   Program Total Costs: Source   Amount
       2a(1). Program offsets applied to
                 occupancy and meals:

       2a(2): Program offsets applied to
                 non-occupancy and meal items

       2b.Offsets for Non-Reimbursable Costs:
       Note: Total non-reimbursable costs listed in line 2b must be detailed on Attachment 5.
2. Subtotal Offsets (Line 2a(1) + Line 2a(2) + Line 2b)   (   )

3.   Net Adjusted Program Costs (LINE 1 minus LINE 2)

4.   Total Program Capacity   (# of unit)   (Type of unit)

5.   Share of Total Capacity Purchased by Contract   (# of units)   (% of line 4)

6.   Negotiated Utilization Factor, if any

7.   Adjusted Capacity Used to Establish Price (LINE 4 x LINE 6)   (# of units)

8.   Unit Rate (LINE 3 DIVIDED BY LINE 7)

9.   Maximum # of Billable Units **(LINE 5 x LINE 6)**

_____
OTHER PRICE CALCULATION METHOD
10.   Enter relevant information:

_____
MAXIMUM OBLIGATION CALCULATION
11. For Unit Rate: Line 8 X Line 9
      For Other Price Calculation Method, Enter Obligation From Line 10
      For Cost Reim.: Enter Reimbursable Cost Total From Program Budget

12.   Invoice Offset   SOURCE   AMOUNT

 12. Subtotal   (   )

13. Maximum Obligation for the Program(LINE 11 minus LINE 12)

14. Capital Budget (from Capital Budget Form), if applicable   _____

15. **Total Maximum Obligation for Program** (LINE 13 **+** LINE 14)

FOR INFORMATION ONLY: Other Revenue Sources (Only if % in LINE 5 is less than 100%)
SOURCE   AMOUNT